Manitowoc County Health Department

COVID-19 VACCINE SCREENING & ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please Print.**

Client's Name (Last, First, Middle Initial): _____ Mother's Maiden Name: _____

Age:_____ Date of Birth (mm/dd/yyyy):_____Gender: Male Female Other

Address:_____City:_____Zip Code:_____

Telephone:_____

Ethnicity: Hispanic Non-Hispanic **Race:** Black/African American American Indian Asian White Other race

Questions for person receiving vaccine

1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours) Yes No

2. Are you currently in your isolation or quarantine period due to COVID-19? Yes No

3. Have you ever received a dose of COVID-19 vaccine? Yes No

If yes, which vaccine?

- ☐ Pfizer
- ☐ Moderna
- ☐ Johnson and Johnson
- ☐ Other _____

3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®,or for which you had to go to the hospital? Yes No

- Was the severe allergic reaction after receiving COVID-19 vaccine? Yes No
- Was the severe allergic reaction after receiving another vaccine or another injectable medication? Yes No

4. Have you received antibody therapy or convalescent plasma for COVID treatment in the past 90 days? Yes No

5. Have you received another vaccine in the past 14 days? Yes No

6. Are you pregnant or breastfeeding? Yes No

YOUR ACKNOWLEDMENT AND SIGNATURE

I have received and/or read the "Fact Sheet for Recipients and Caregivers." I have had a chance to ask questions that were answered to my satisfaction.

I understand the benefits and risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA.

I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors.

I understand the benefits and risks of the vaccine and I consent to receive it. I authorize designed staff to administer the vaccine. I release Manitowoc County Health Department and its staff from any and all liability for an injury, condition, or damage incurred due to my receipt of the vaccine.

Consent Obtained (Signature)_____ Date:_____

For Office Use Only:

Vaccine	Site	Trade Name/Manufacturer Lot Number	Expiration Date
COVID-19 Janssen	**RD LD**		
Signature and Title – Person Administering Vaccine:		**Date:**	